

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 18&21 Film G193 3-13-56 ams

01811

1825

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

| | | | | | | | |
|---|-------------------------------|---|---------------------------------------|--|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>Md</u> | | COUNTY <u>Harford</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Harford</u> | | <u>2 Mns. - 5 days</u> | | TOWN <u>Perryman</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>Maple Ave</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Ralph</u> (Middle) <u>William</u> (Last) <u>Ashford</u> | | | | (Month) <u>Feb.</u> (Day) <u>23</u> (Year) <u>1956</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>Sept 1 - 1934</u> | 9. AGE last birthday <u>21</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ray Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Heating Business</u> | | 11. BIRTHPLACE (State or foreign country) <u>Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | |
| 13. FATHER'S NAME <u>William Franklin Ashford</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Cellic Elizabeth Shrader</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>218-32-6941</u> | | 17. INFORMANT & ADDRESS <u>Wm. F. Ashford, Perryman Md.</u> | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 825X IMMEDIATE CAUSE (A) <u>Brain stem damage</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Skull fracture</u> | | | | 2 mos. | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Accident, Auto</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Highway</u> | | 21c. WHERE DID INJURY OCCUR? (City or town) <u>Cresswell, Rt#543</u> (County) (State) <u>Md.</u> | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>12/18/55</u> | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work | | 21f. HOW DID INJURY OCCUR? <u>Automobile accident</u> | | | |
| 22. I hereby certify that I attended the deceased from <u>Dec. 18, 1955</u> , to <u>Feb. 23, 1956</u> , that I last saw the deceased alive on <u>Feb. 23, 1956</u> , end that death occurred at <u>12:05 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Wm. K. Shrader</u> | | | | ADDRESS (Street, city, town, state) <u>Harford Md</u> DATE SIGNED <u>2-23-56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Feb. 26-1956</u> | | NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Aberdeen Md</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>U. L. Lewis m d</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Tarring</u> | | ADDRESS <u>Aberdeen Md.</u> | |
| DATE <u>Feb. 21-1956</u> | | | | | | | |

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 29 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
3478 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

01812

Reg. Dist. No. 185

| | | | |
|--|----------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH COUNTY <u>Baltimore</u> <u>Maryland</u> | | 2. USUAL RESIDENCE (HOME) OF DECEASED COUNTY <u>Baltimore</u> <u>Maryland</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hamlet Chase</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hamlet Chase</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural, give location) <u>Pennington St.</u> | |
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE OF DEATH | |
| <u>Willie</u> (First) <u>Barfield</u> (Middle) | | <u>2/27/56</u> (Month) <u>19</u> (Year) | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH |
| | | | <u>5/3/1902</u> <u>53</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTH PLACE (State or foreign country) | |
| <u>laborer</u> | | <u>North Carolina</u> | |
| 13. FATHER'S NAME <u>Willis Barfield</u> | | 14. MOTHER'S MAIDEN NAME <u>Josephine ? Barfield</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 17. INFORMANT AND ADDRESS | |
| <u>Unknown</u> | | <u>Beatrice Johnson</u> <u>1519 Wilmore St.</u> <u>Baltimore, Md.</u> | |

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Erosion cerebrum

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Amputation L thigh

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☒ Not while at work ☐

HOW DID INJURY OCCUR?

2/27/56 4A m.into accidentinto accident

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Lorrell C Palmer MD Deputy Medical Examiner2/27/56

23. BURIAL, CREMATION OR MOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. GENERAL DIRECTOR

ADDRESS

Feb 27 1956 G. L. Smith MDFlanagan & Fink Williamston, N.C.

BUREAU V. S.

FEB 29 1936

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01813

1843 CERTIFICATE OF DEATH

Reg. Dist. No. 181

| | | | | | | | |
|---|----------------------------------|--|---|---|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <i>Harford</i> | | MARYLAND | | STATE <i>Maryland</i> | | COUNTY <i>Harford</i> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Aberdeen</i> | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen Rural #1</i> | | TOWN <i>Aberdeen Rural #1</i> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Parsius Run. Rural #1</i> | | | | STREET ADDRESS (If rural give location) <i>near Parsius Run.</i> | | | |
| 3. NAME OF DECEASED (Type or Print) <i>Varney Arthur Beall</i> | | | | 4. DATE OF DEATH (Month) <i>Feb.</i> (Day) <i>7th</i> (Year) <i>1956</i> | | | |
| 5. SEX <i>male</i> | 6. COLOR OR RACE <i>white</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i> | 8. DATE OF BIRTH <i>Jan 9th 1882</i> | 9. AGE last birthday <i>74</i> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer self emp.</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>farmer</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Leunel H. Beall</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Charlotte Wilg's</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>none</i> | | 17. INFORMANT & ADDRESS <i>Wm Varney H. Beall - Aberdeen #1</i> | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 443X IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSE(S) DUE TO (B) <i>Chronic Myocarditis - Hypertension</i> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <i>4-12</i> 19 <i>46</i> , to <i>Feb 7</i> 19 <i>56</i> , that I last saw the deceased alive on <i>Feb 6</i> 19 <i>56</i> , and that death occurred at <i>10 PM</i> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>[Signature]</i> | | M.D. <i>John De Grace</i> | | ADDRESS (Street, city, town, state) <i>Bel Air Md</i> | | DATE SIGNED <i>2/8/56</i> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | DATE THEREOF <i>2/8/56</i> | | NAME OF CEMETERY OR CREMATORY <i>Wt. Zion Cemetery</i> | | LOCATION (City, town, of county) (State) <i>Bel Air Md Maryland</i> | |
| 24. REC'D BY REGISTRAR <i>Feb 11-56</i> | | REGISTRAR'S SIGNATURE <i>Thelma G. Perry</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>John E. Garrison</i> ADDRESS <i>Aberdeen Md.</i> | | | |

1913 CERTIFICATE OF DEATH

Dec 14 1913

DEATH
CERTIFICATE

RECEIVED

BUREAU V. 2

FEB 14 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A153 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01814

1844

CERTIFICATE OF DEATH

Reg. Dist. No. 182

| | | | | | | | |
|---|-------------------------|---|-------------------------|---|------------------------|---|-------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>ROCKS</u> | | COUNTY <u>Harford</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Rural, Rocks</u> | | <u>Months</u> | | TOWN <u>ROCKS</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| (First) <u>Thomas</u> (Middle) <u>W.</u> (Last) <u>Bosley</u> | | | | Feb. 24 19 56 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Male</u> | <u>White</u> | <u>Married</u> | <u>MARCH 31/1988</u> | <u>67</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Laborer</u> | | <u>Farming</u> | | <u>Maryland</u> | | <u>U.S.A.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>THOMAS E Bosley</u> | | | | <u>Elizabeth Bosley</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| | | | | <u>Elizabeth Bosley Rocks</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 420.1 IMMEDIATE CAUSE (A) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| <u>Coronary Thrombosis</u> | | | | <u>1 hr.?</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| (B) Chr. Cardio Vascular disease with hypertension | | | | <u>?</u> | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| <u>Cerebral thrombosis with hemiplegia</u> | | | | <u>Mar. 1954</u> | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>3-19</u>, 19 <u>54</u>, to <u>Feb. 24</u>, 19 <u>56</u>, that I last saw the deceased alive on <u>Feb. 22</u>, 19 <u>56</u>, and that death occurred at <u>56</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| <u>Willard P. Hudson</u> | | | | <u>M.D. Forest Hill, Md.</u> | | <u>2-25-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | |
| <u>BURIAL</u> | | <u>Feb 27-56</u> | | <u>MT ZION</u> | | <u>Beltir Md</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | | |
| <u>DATE 2-28-56</u> | | <u>Purville Fowood</u> | | <u>Martin E. B. Jarrett</u> | | | |

CERTIFICATE OF DEATH

0181

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

MARCH 18 1910

THOMAS E. BARRY

THOMAS E. BARRY

THOMAS E. BARRY

BUREAU V. S.

MAR 2 1910

RECEIVED

THOMAS E. BARRY

RECEIVED

1826

CERTIFICATE OF DEATH

Reg. Dist. No.

185

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u> | | | | c. LENGTH OF STAY IN 1b <u>1 1/2 HRS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11 HARFORD MEMORIAL HOSP.</u> | | | | d. STREET ADDRESS <u>517 N. Adams</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>GORMAN</u> Last <u>BOYD</u> | | | | 4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>22</u> Year <u>1956</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1/25/07</u> | |
| 9. AGE (In years last birthday) <u>49</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>MICHAEL P. BOYD</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARGARET CONNORS</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>W.W.I</u> | | | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT <u>John Boyd, 517 N. Adams Harf. Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardiovascular</u> <u>420.1</u> DUE TO <u>Hypertension Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u> </u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u> </u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>1/10</u> , 19 <u>52</u> , to <u>2/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/22</u> , 19 <u>56</u> , and that death occurred at <u>10:40</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Harford Md</u> DATE SIGNED <u>2/23/56</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Charles J. Foley</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>Harford Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>2/25/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Elm</u> | | 22d. LOCATION (City, town, or county) (State) <u>Harford Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lawrence Rm, Harford Md</u> | | | | ADDRESS <u> </u> | | 24a. REC'D BY REGISTRAR DATE <u>2-25-56</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|-----------------------------------|--|-----------------------------|--|------------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | |
| 4. Date of death | | 5. Time of death | | 6. Place of death | |
| 7. Cause of death | | 8. Manner of death | | 9. Signature of physician | |
| 10. Signature of registrar | | 11. Signature of informant | | 12. Signature of witness | |
| 13. Signature of funeral director | | 14. Signature of undertaker | | 15. Signature of cemetery | |
| 16. Signature of mortician | | 17. Signature of embalmer | | 18. Signature of transporter | |
| 19. Signature of interment | | 20. Signature of burial | | 21. Signature of cremation | |
| 22. Signature of other | | 23. Signature of other | | 24. Signature of other | |
| 25. Signature of other | | 26. Signature of other | | 27. Signature of other | |
| 28. Signature of other | | 29. Signature of other | | 30. Signature of other | |
| 31. Signature of other | | 32. Signature of other | | 33. Signature of other | |
| 34. Signature of other | | 35. Signature of other | | 36. Signature of other | |
| 37. Signature of other | | 38. Signature of other | | 39. Signature of other | |
| 40. Signature of other | | 41. Signature of other | | 42. Signature of other | |
| 43. Signature of other | | 44. Signature of other | | 45. Signature of other | |
| 46. Signature of other | | 47. Signature of other | | 48. Signature of other | |
| 49. Signature of other | | 50. Signature of other | | 51. Signature of other | |
| 52. Signature of other | | 53. Signature of other | | 54. Signature of other | |
| 55. Signature of other | | 56. Signature of other | | 57. Signature of other | |
| 58. Signature of other | | 59. Signature of other | | 60. Signature of other | |
| 61. Signature of other | | 62. Signature of other | | 63. Signature of other | |
| 64. Signature of other | | 65. Signature of other | | 66. Signature of other | |
| 67. Signature of other | | 68. Signature of other | | 69. Signature of other | |
| 70. Signature of other | | 71. Signature of other | | 72. Signature of other | |
| 73. Signature of other | | 74. Signature of other | | 75. Signature of other | |
| 76. Signature of other | | 77. Signature of other | | 78. Signature of other | |
| 79. Signature of other | | 80. Signature of other | | 81. Signature of other | |
| 82. Signature of other | | 83. Signature of other | | 84. Signature of other | |
| 85. Signature of other | | 86. Signature of other | | 87. Signature of other | |
| 88. Signature of other | | 89. Signature of other | | 90. Signature of other | |
| 91. Signature of other | | 92. Signature of other | | 93. Signature of other | |
| 94. Signature of other | | 95. Signature of other | | 96. Signature of other | |
| 97. Signature of other | | 98. Signature of other | | 99. Signature of other | |
| 100. Signature of other | | 101. Signature of other | | 102. Signature of other | |

BUREAU V. S.

FEB 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH
1845 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

01816

Reg. Dist. No. 18

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> TOWN <u>Harford</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural #1 - (Robin Hood Road)</u> | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> TOWN <u>Harford</u> STREET ADDRESS (If rural, give location) <u>Robin Hood Road Area</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>Walter Charles Burkent</u> | | 4. DATE OF DEATH (Month) <u>February</u> (Day) <u>20</u> (Year) <u>1956</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>June 28 - 1879</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer, self emp</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | 9. AGE last birthday <u>76</u> yrs. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13. FATHER'S NAME <u>Thomas Burkent</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Herman</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u> </u> | | 16. SOCIAL SECURITY NO. <u>218-07-3168</u> | |
| 17. INFORMANT AND ADDRESS <u>Ted Burkent #2 Baldwin Circle</u> | | 18. MEDICAL CERTIFICATION | |

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Arteriosclerotic CV disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY? Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Ronald E Palmer M.D. Deputy Medical Examiner Harford County 2/20/56

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb 22 - 1956 Nellie G. Perry John E. Tarring Aberdeen Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 27 1950
BUCKLEY K. J.

1827

CERTIFICATE OF DEATH

Reg. Dist. No.

01847

| | | | | | | | |
|--|----------------------------------|--|-------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u> | | c. LENGTH OF STAY IN 1b <u>56</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u> | | | | d. STREET ADDRESS <u>146 Bloomsburg Ave.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Victor</u> Middle <u>George</u> Last <u>Coakley</u> | | | | 4. DATE OF DEATH Month <u>FEB.</u> Day <u>27</u> Year <u>1956</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/6/1899</u> | 9. AGE (In years last birthday) <u>56</u> yrs. | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ | IF UNDER 24 HRS Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Plumber U.S. Armed Forces</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Eugene Coakley</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Myrtle Gilbert</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>199-174615</u> | | 17. INFORMANT <u>MRS. Willie S. Coakley</u> Address <u>Havre de Grace Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardio Vascular</u> <u>Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aliscian</u> DUE TO <u>Acute Myocarditis</u> (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>Feb-26, 1956</u> to <u>Feb-27, 1956</u> , that I last saw the deceased alive on <u>Feb 27, 1956</u> , and that death occurred at <u>4:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ | | | | | | | |
| ACTUAL SIGNATURE <u>Charles J. Feltz</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>William McGowan Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>MAR. 1, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u> | | 22d. LOCATION (City, town, or county) _____ (State) <u>MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> | | | | ADDRESS <u>Havre de Grace Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>Feb-29-56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis Md.</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 5 1

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 1846 FOR MEDICAL EXAMINERS

01818

Reg. Dist. No. 1-5

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>HARFORD</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Oakington</u> | | STREET ADDRESS (If rural, give location) <u>Connetquot St.</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>George Amos Curry</u> | | 4. DATE OF DEATH (Month) <u>February</u> (Day) <u>16</u> (Year) <u>1956</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>JUNE 5, 1883</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u> | 9. AGE last birthday <u>72</u> yrs. <u>11</u> under 1 year <u>11</u> under 24 hrs. Months Days Hours Min. |
| 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Thomas Curry</u> | | 14. MOTHER'S MAIDEN NAME <u>Susan Motuary</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY No. <u>—</u> | |
| 17. INFORMANT AND ADDRESS <u>Mrs. Sarah Jane Curry Harford Grace</u> | | | |

18. MEDICAL CERTIFICATION

| | | |
|--|--|--|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH <u>—</u> |
| (a) Immediate cause <u>Arteriosclerotic CV disease</u> | | |
| (b) Antecedent cause(s) Disease or condition(s), if any, giving rise to the above cause stating the underlying cause last <u>—</u> | | |

| | |
|---|--|
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | |
|---|--|

| | | |
|------------------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION <u>0</u> | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
|------------------------------------|----------------------------------|---|

| | | | | |
|--|--|-----------------------|----------|---------|
| 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. TIME (Month) (Day) (Year) (Hour) OF INJURY | PLACE (Home, farm, factory, street, or office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
| INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | | |

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☒ suicide ☐ homicide ☐ undetermined ☐

| | | | |
|--|---|--|--|
| SIGNATURE <u>Lerald E Palmer</u> | | DATE SIGNED <u>2/16/56</u> | |
| (Degree or title) <u>M.D., Deputy Medical Examiner BdA in Md.</u> | | ADDRESS <u>Harford Co. Md.</u> | |
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | DATE THEREOF <u>2-18-1956</u> | NAME OF CEMETERY OR CREMATORY <u>Harmony Ch. Yard</u> | LOCATION (City, town, or county) <u>Harford Co. Md.</u> |
| DATE REC'D BY LOCAL REG. <u>2-16-17-1956</u> | REGISTRAR'S SIGNATURE <u>U. L. Lewis</u> | 24. GENERAL DIRECTOR <u>W. Madison Welch</u> | ADDRESS <u>Harford Grace, Md.</u> |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WILLIAM V. S.

FEB

1950

1828

CERTIFICATE OF DEATH

018185-

Reg. Dist. No.

| | | | |
|--|------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-De-Grace</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u> | |
| c. LENGTH OF STAY IN 1b <u>8 days</u> | | d. STREET ADDRESS <u>Arch St</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>W.</u> Last <u>Davis</u> | | 4. DATE OF DEATH Month <u>February</u> Day <u>24</u> Year <u>1956</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/1/75</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | IF UNDER 1 YEAR: Months <u>24</u> Days <u>19</u> Hours <u>56</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fisherman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Edward K. Davis</u> | | 14. MOTHER'S MAIDEN NAME <u>Cecilia Kelly</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Lizzie Davis (wife) Perryville, Md.</u> | |
| 17. INFORMANT <u>Lizzie Davis (wife) Perryville, Md.</u> | | Address <u>Perryville, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>444.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Sclerosis - Arterio Sclerosis</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>August 7, 1951</u> to <u>Feb. 24, 1956</u> that I last saw the deceased alive on <u>Feb. 24, 1956</u> , and that death occurred at <u>8:10 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>C. J. Benson</u> M.D. | | ADDRESS (Street, city or town, state) <u>Port Deposit, Md.</u> DATE SIGNED <u>1724-12-57</u> | |
| PHYSICIAN'S NAME (Type) <u>C. J. BENSON</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>2-27-1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>North East</u> | 22d. LOCATION (City, town, or county) (State) <u>North East, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Patterson & Son, Perryville, Md.</u> | | ADDRESS <u>Perryville, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>DATE 2-25-1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>C. J. Benson M.D.</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1960 A. 8

181

1847 CERTIFICATE OF DEATH

Reg. Dist. No. 180

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon | | c. LENGTH OF STAY IN 1b 50 yrs.. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Rebecca Middle Dorsey Last Dorsey | | 4. DATE OF DEATH Month Feb. Day 19 Year 1956 | |
| 5. SEX female | 6. COLOR OR RACE colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 9, 1875 |
| 9. AGE (In years last birthday) 80 yrs. | | 10. IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min. 80 | 11. IF UNDER 24 HRS. Hours 80 Min. 80 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Servant | | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Abraham Dorsey | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT Mrs. Edith Harris | | Address Abingdon, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular disease DUE TO (c) Hypertensive Cardiovascular disease | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 12/23, 1955 to 2/19, 1956 , that I last saw the deceased alive on 2/16, 1956 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George T. Stansbury M.D. 569 Revolution St., Havre de Grace 2/1956 Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | |
| 22b. DATE THEREOF Feb. 22, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY John Wesley | |
| 22d. LOCATION (City, town, or county) (State) Abingdon, Harford, Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard K. Mc Comas & Son ADDRESS Abingdon, Md. | | 24a. REC'D BY REGISTRAR DATE Feb 22, 1956 | |
| 24b. REGISTRAR'S SIGNATURE Norma | | | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN **HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS M C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01821

1848 CERTIFICATE OF DEATH

Reg. Dist. No. 182

| | | | | | | | |
|--|------------------|--|-----------------------------------|---|---|--|------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Hartford</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Hartford</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR | |
| TOWN <u>Jarretttsville</u> | | <u>70 yrs</u> | | TOWN <u>Jarretttsville</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>Alice Gertrude Eggleston</u> | | | | <u>Feb 6th 1956</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Female</u> | <u>White</u> | <u>Single</u> | <u>Dec 13 1877</u> | <u>78</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| <u>Teacher (Retired)</u> | | | | | <u>Hess, Hartford Md</u> | | <u>USA</u> |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Joseph E. Eggleston</u> | | | | <u>Emma Frances Blaney</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | |
| <u>No</u> | | | | | | <u>Miss Estelle Eggleston Jarretttsville Md</u> | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) <u>Malnutrition</u> | | | | | | <u>6 months</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Lack of Appetite & Anemia</u> | | | | | | <u>1 year</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Carcinoma of Small Bowel</u> | | | | | | <u>1 year</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | <u>NONE</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY / YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| <u>NONE</u> | | <u>NONE</u> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>49</u> , to <u>JUN. 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>JAN. 30</u> , 19 <u>56</u> , and that death occurred at <u>5:20</u> M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>W. J. [illegible]</u> | | | | DATE SIGNED <u>Feb. 6, 1956</u> | | | |
| M.D. <u>Jarretttsville, Md.</u> | | | | <u>2/7/56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>Feb 8-56</u> | | <u>Jarretttsville</u> | | <u>Jarretttsville Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE <u>2-10-56</u> | | <u>Priscilla Lawwood</u> | | <u>Martha G. Kutz Jarretttsville Md.</u> | | | |

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be attached for use as a burial transit permit.

VS 1-55 11M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01822

1849 CERTIFICATE OF DEATH

Reg. Dist. No. 182

| | | | |
|--|--|--|------------------------------------|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <u>HARFORD</u> | MARYLAND | STATE <u>Maryland</u> | COUNTY <u>HARFORD</u> |
| CITY OR TOWN <u>Jarrettsville (Rural)</u> | LENGTH OF STAY (in this place) <u>86 yrs.</u> | CITY OR TOWN <u>(RURAL) JARRETTSVILLE</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) | |
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE OF DEATH | |
| (First) <u>George</u> (Middle) <u>Edward</u> (Last) <u>EMRICK</u> | | (Month) <u>Feb</u> (Day) <u>3rd</u> (Year) <u>1956</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u> | 8. DATE OF BIRTH <u>Feb 2 1870</u> |
| 9. AGE last birthday <u>86</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Retired</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Jarrettsville Md</u> | |
| 13. FATHER'S NAME <u>John Emrick</u> | | 14. MOTHER'S MAIDEN NAME <u>Catharine Hess</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT & ADDRESS <u>Charles H. Goluman, m.d., Rockers Rd</u> | | 18. MEDICAL CERTIFICATION | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC Heart Disease</u> | | <u>25 yrs</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized ARTERIOSCLEROSIS</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CHRONIC BRONCHITIS</u> | | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>M.</u> | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>20 June 1955</u> , to <u>3 FEB</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1 Feb</u> , 19 <u>56</u> , and that death occurred at <u>530 AM</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>Thomas A. Mosley Jr.</u> | | DATE SIGNED <u>3 Feb 56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 24. REC'D BY REGISTRAR | |
| DATE THEREOF <u>Feb 5-56</u> | | REGISTRAR'S SIGNATURE <u>Priscilla Howard</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Salem</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>William S. Kuntz</u> | |
| LOCATION (City, town, or county) <u>Jarrettsville Harford Md</u> | | ADDRESS | |

11

RECEIVED

FEB

1967

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

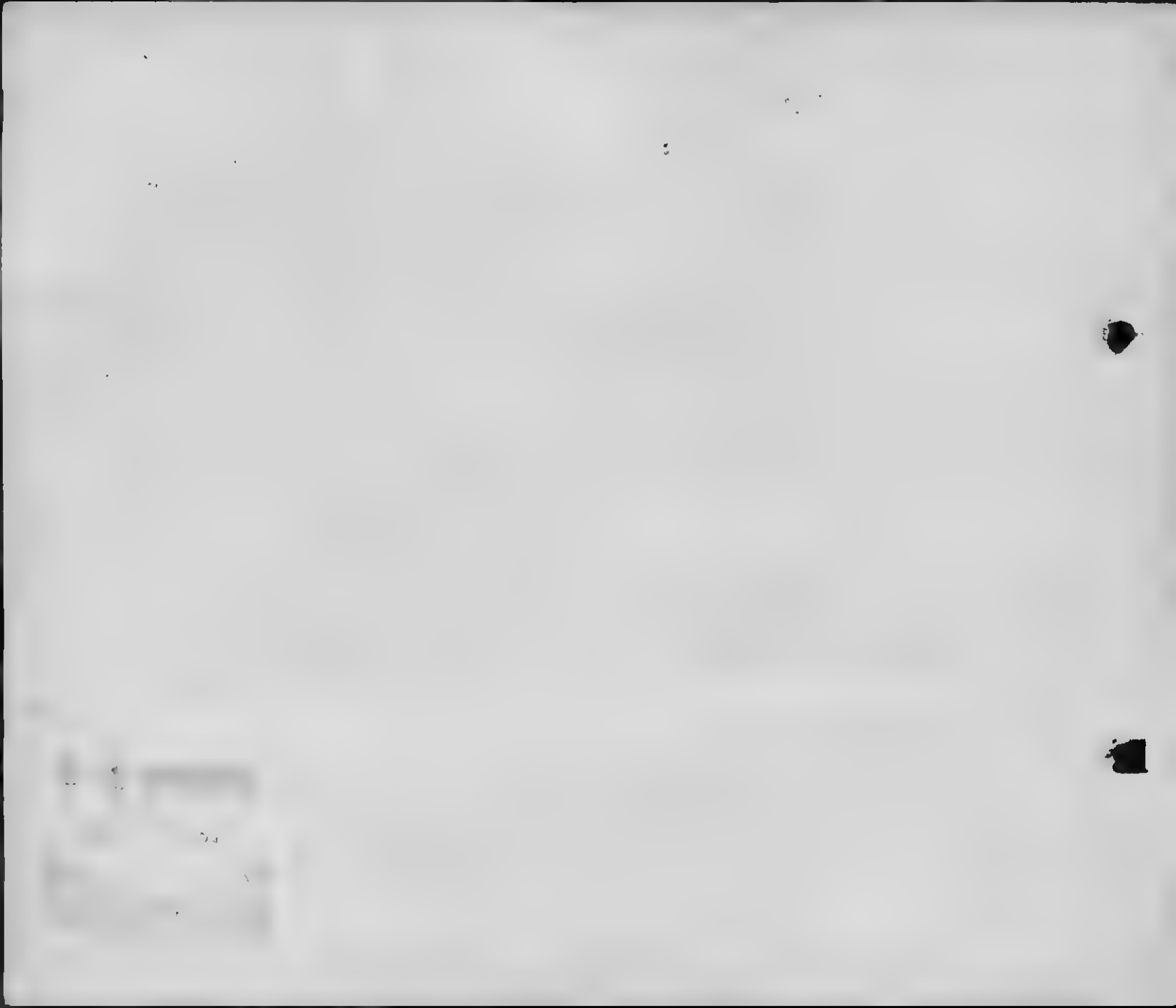
1850
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01823
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 47

| | | | |
|--|--------------------------------|---|----------------------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY | Harford | STATE | Maryland |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits write RURAL and give nearest town) | COUNTY |
| TOWN | | TOWN | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | 4. DATE OF DEATH (Month) (Day) (Year) | |
| (Type or Print) MELVIN JACKSON ESTES | | 2 4 19 56 | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: |
| Male | White | Single | 7-26 |
| 9. AGE last birthday: | | 10. BIRTHPLACE (State or foreign country): | |
| 17 yrs. | | Baltimore, Maryland | |
| 11. BIRTHPLACE (State or foreign country): | | 12. CITIZEN OF WHAT COUNTRY? | |
| Baltimore, Maryland | | U.S.A. | |
| 13. FATHER'S NAME: | | 14. MOTHER'S MAIDEN NAME: | |
| John S. Jackson | | Mary S. Estes (maiden name) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY No.: | |
| Yes 11-16-55 to present | | 17. INFORMANT & ADDRESS: | |
| | | Navy Records | |
| 18. MEDICAL CERTIFICATION | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | INTERVAL BETWEEN ONSET AND DEATH |
| Immediate cause (a) DUE TO | | | |
| Antecedent cause(s) (b) DUE TO | | | |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION: 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 0 | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | |
| 21c. (City or town) (County) (State) | | 21d. (City or town) (County) (State) | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 2 4 56 2230M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | 21g. HOW DID INJURY OCCUR? | |
| Automobile Accident | | Automobile Accident | |
| 22. I hereby certify that I took charge of the remains described above; held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> | | | |
| SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED | |
| M. D. | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 2-5-56 | |
| ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): | | DATE THEREOF | |
| Burial | | 2-5-56 | |
| NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Rio Church Cem. | | Chesapeake, Md. | |
| DATE REC'D BY LOCAL REG. | | REGISTRAR'S SIGNATURE | |
| | | C. S. Jackson | |
| 24. FUNERAL DIRECTOR | | ADDRESS | |
| C. S. Jackson | | C. S. Jackson, 244 E. 11th St. | |



INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

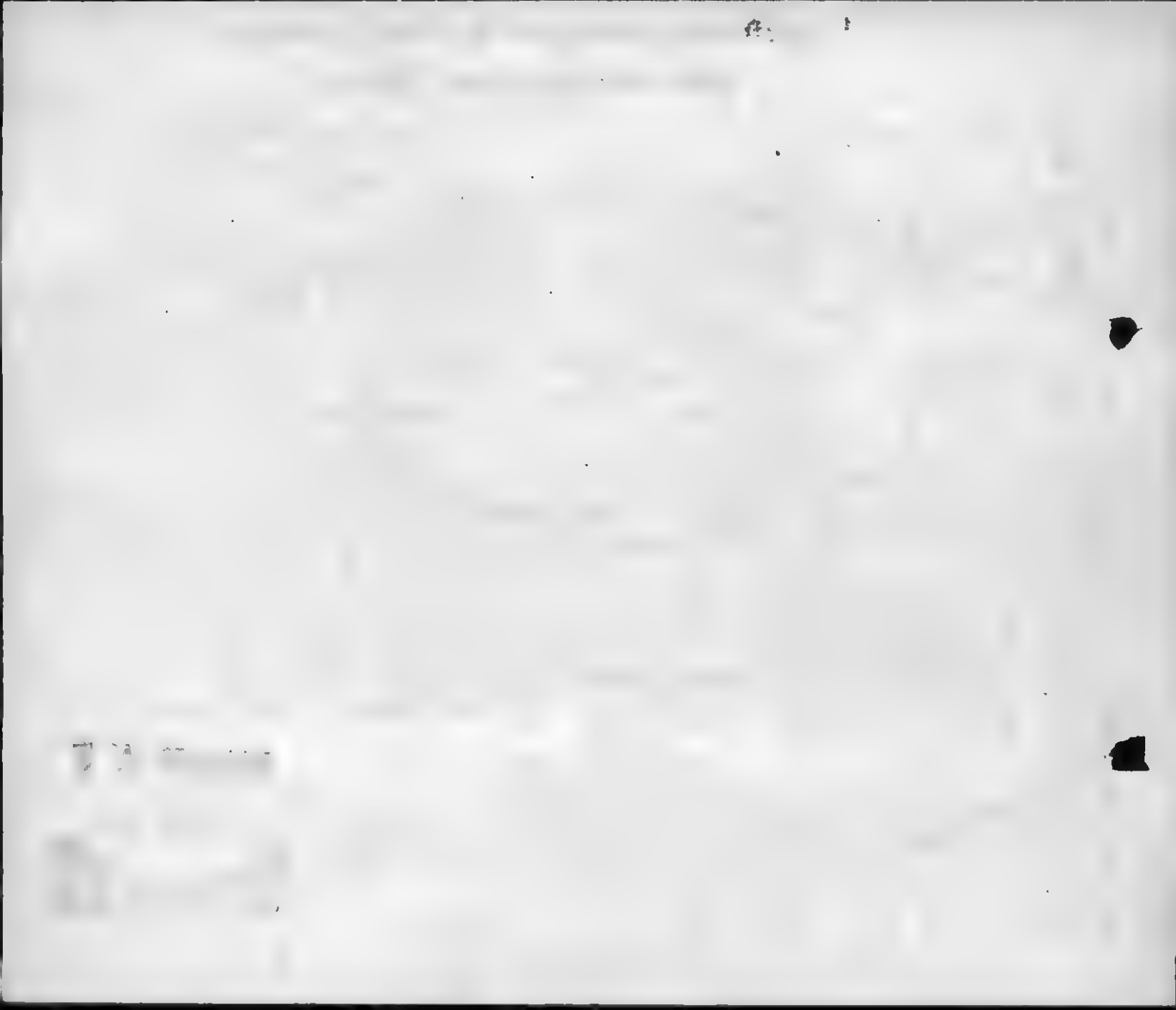
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01824

1829 CERTIFICATE OF DEATH

Reg. Dist. No. 181

| | | | | | | | |
|---|-----------------------------|--|-------------------------------------|---|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <i>Harford</i> | | STATE <i>Maryland</i> COUNTY <i>Harford</i> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| CITY OR TOWN <i>Aberdeen</i> | | LENGTH OF STAY (in this place) | | CITY OR TOWN <i>Aberdeen</i> | | STREET ADDRESS (If rural give location) | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>#401 Wynnton Ave.</i> | | | | STREET ADDRESS <i>#401 Wynnton Ave.</i> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <i>Wilton Eugene Fassnacht</i> | | | | <i>Feb 17 1956</i> | | | |
| 5. SEX <i>Male</i> | 6. CO. OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i> | 8. DATE OF BIRTH <i>Dec 31 1878</i> | 9. AGE last birthday <i>77</i> Yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman Retired</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Gasoline Industries</i> | | 11. BIRTHPLACE (State or foreign country) <i>Ohio</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Albert Fassnacht</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Hattie Lasher</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>223-01-2287</i> | | 17. INFORMANT & ADDRESS <i>Wilton E. Fassnacht, Aberdeen Md.</i> | | | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 4221 IMMEDIATE CAUSE (A) <i>Cerebral Ischemic Circulation Failure</i> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <i>Thrombosis</i> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Arterio Sclerosis</i> | | | | | | | |
| 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <i>2/10</i> , 19 <i>56</i> , to <i>2/17</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>2/17</i> , 19 <i>56</i> , and that death occurred at <i>11:45 P.M.</i> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>Wilton E. Fassnacht</i> M.D. | | | | DATE SIGNED <i>2/18/56</i> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i> | | DATE THEREOF <i>Feb 18-1956</i> | | NAME OF CEMETERY OR CREMATORY <i>East Akron Cemetery</i> | | LOCATION (City, town, or county) (State) <i>Akron, Ohio</i> | |
| 24. REC'D BY REGISTRAR <i>Mellie R. Perry</i> | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>John E. Farringham</i> | | ADDRESS <i>Aberdeen Md.</i> | |
| DATE <i>Feb 18-56</i> | | | | | | | |



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1830
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 181

01825

| | | | |
|---|--------------------------------|--|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Harford</u> | MARYLAND | STATE <u>Maryland</u> COUNTY <u>Harford</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Aberdeen</u> | LENGTH OF STAY (in this place) | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Aberdeen</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>#6 Post Road.</u> | | STREET ADDRESS (If rural, give location) <u>#6 Post Road.</u> | |
| 3. NAME OF DECEASED: | | 4. DATE OF DEATH | |
| (First) <u>Oliver</u> | (Middle) <u>D</u> | (Last) <u>Frock</u> | (Month) <u>February</u> (Day) <u>9</u> (Year) <u>1956</u> |
| 5. SEX: <u>Male</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u> | 8. DATE OF BIRTH: <u>June 17 - 1895</u> |
| 9. AGE last birthday: <u>60</u> yrs. | | 10. BIRTHPLACE (State or foreign country): <u>West Virginia</u> | |
| 11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Electrician</u> | | 12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>John Thomas Frock</u> | | 14. MOTHER'S MAIDEN NAME: <u>Elizabeth Barker</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes</u> <u>WW I</u> | | 16. SOCIAL SECURITY NO.: <u>220-22-0348</u> | |
| 17. INFORMANT'S ADDRESS: <u>Berkley Springs W. Va.</u> | | 18. MEDICAL CERTIFICATION | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | INTERVAL BETWEEN ONSET AND DEATH | |
| Immediate cause (a) <u>Arteriosclerotic C.V. Disease</u> | | | |
| DUE TO | | | |
| Antecedent cause(s) (b) _____ | | | |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) _____ | | | |
| DUE TO | | | |
| 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | |
| | | | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | |
| 21c. (City or town) (County) (State) | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| SIGNATURE <u>Lowell C Palmer</u> | | M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u> | | DATE THEREOF <u>2/10/56</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Greenway Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Berkley Springs W. Va.</u> | |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Feb. 10 - 56</u> | | 24. FUNERAL DIRECTOR <u>John F. Barring</u> ADDRESS <u>Aberdeen Md.</u> | |



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1851

CERTIFICATE OF DEATH

01826

Reg. Dist. No. 181

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH COUNTY <u>HARFORD</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>PERRYMAN</u> LENGTH OF STAY (in this place) <u>10 YRS</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>HARFORD</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>PERRYMAN</u> STREET ADDRESS (If rural give location) | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARY ELLEN GILBERT</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 18 1956</u> | |
| 5. SEX <u>FEMALE</u> | 6. CO. OR RACE <u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>DEC. 10, 1888</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> | 9. AGE last birthday <u>67</u> yrs. |
| 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>RICHARD HANNOCK</u> | | 14. MOTHER'S MAIDEN NAME <u>CATHERINE V. HOLLOWAY</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT & ADDRESS <u>DAKLEY B. GILBERT, PERRYMAN MD.</u> | | | |
| 18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Ironie Myocardial Degeneration</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Diabetes Mellitus</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21a. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>Feb. 17, 1956</u> , to <u>Feb. 18, 1956</u> , that I last saw the deceased alive on <u>Feb. 17, 1956</u> , and that death occurred at <u>12:45 P.</u> M., from the causes and on the date stated above. SIGNATURE <u>Edward D. Holloway, M.D.</u> ADDRESS (Street, city, town, state) <u>Perryman, Md.</u> DATE SIGNED | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | DATE THEREOF <u>2-21-1956</u> | NAME OF CEMETERY OR CREMATORY <u>BAKER'S CEM.</u> | LOCATION (City, town, or county) (State) <u>HARFORD MD.</u> |
| 24. REC'D BY REGISTRAR DATE <u>Feb. 20-56</u> | REGISTRAR'S SIGNATURE <u>Nellie Q. Perry</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>HAVRE DE GRACE MD.</u> | |

8 10 10 10

FEB

REC 100

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01827

1831 CERTIFICATE OF DEATH

Reg. Dist. No. 185

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Harford</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR | |
| TOWN <u>Harvre de Grace</u> | | <u>3 DAYS</u> | | TOWN <u>Harvre de Grace</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u> | | | | STREET ADDRESS (If rural, give location) <u>3185 Union Street</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>IRA Herman Hall</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>February 16 1956</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | | 8. DATE OF BIRTH <u>5/7/1905</u> | |
| 9. AGE last birthday <u>50</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CIVILIAN GUNNER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>A.P.G.</u> | | 11. BIRTHPLACE (State or foreign country) <u>VA.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Robert G. Hall</u> | | 14. MOTHER'S MAIDEN NAME <u>Laura B. Hall</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. <u>214-18-6440</u> | | 17. INFORMANT & ADDRESS <u>3185 UNION, AVE. VICTORIA HALL HARVRE DE GRACE</u> | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Hemorrhage</u> | | | | <u>11 days</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension Cardiovascular Disease</u> | | | | <u>yes</u> | | | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Feb 16, 1956</u> to <u>Feb 16, 1956</u> , that I last saw the deceased alive on <u>Feb 16, 1956</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Frederick J. Stetson</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>1711 Chil Bldg. Aberdeen Md.</u> | | DATE SIGNED <u>2/16/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | DATE THEREOF <u>2-19-1956</u> | | NAME OF CEMETERY OR CREMATORY <u>DORLINGTON CEM.</u> | | LOCATION (City, town, or county) (State) <u>HARFORD CO. MD.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>C. F. Lewis</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>M. A. P. Madison Mitchell</u> | | ADDRESS <u>HARVRE DE GRACE</u> | |
| DATE <u>Feb. 17 - 1956</u> | | | | | | | |

RECEIVED

FEB

1968

1832

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 181

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH: COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Alabama</u> COUNTY <u>Jefferson</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Aberdeen</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Birmingham</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Flying Clipper Trailer Court</u> | | STREET ADDRESS (If rural, give location) | |
| 3. NAME OF DECEASED (Type or Print) <u>Pierce Morgan Hendry</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>February 11 1956</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u> | 8. DATE OF BIRTH <u>Oct 25-1911</u> |
| 9. AGE last birthday <u>44</u> yrs. | | 10. AGE last birthday If under 1 year: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet metal worker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Sheet metal</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Alabama</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Robert H. Hendry</u> | | 14. MOTHER'S MAIDEN NAME <u>Lilly Brooks</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes War II</u> | | 16. SOCIAL SECURITY No. <u>-</u> | |
| 17. INFORMANT AND ADDRESS <u>Robert's Valley Chapel Funeral Home, Birmingham Ala.</u> | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

A sphinxia due to fire

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.PLACE (Home, farm, factory, street, OF office bldg., etc.) Home INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY 2/11/56 8 AMINJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

His trailer caught fire22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Leland C PalmerMD Deputy Medical Examiner2/11/56

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb. 11-1956Nellie G. PerryJohn G. Farving Aberdeen Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01831

1852

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH- COUNTY <u>HARFORD</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford Co.</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL</u> <u>ABERDEEN</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS <u>Route 40 R.D. #1 Aberdeen</u> Md. | |
| 3. NAME OF DECEASED (Type or Print) | (First) <u>FELIX</u> | (Middle) <u>A.</u> | (Last) <u>McNALLY</u> |
| 5 SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>1876</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co</u> | 9. AGE last birthday <u>80</u> yrs. If under 1 year: Months <u>10</u> Days <u>10</u> Hours <u>19</u> Min. <u>56</u> |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Felix A. McNally</u> | | 14. MOTHER'S MAIDEN NAME <u>Alice McGovern</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (known) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY No. | |
| 17. INFORMANT AND ADDRESS <u>Mrs. C.M. Walker-Route 40 R.D.1</u> | | <u>Aberdeen, Md.</u> | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | |
|---|--|--|
| 44- Immediate cause | (a) <u>intracerebral hemorrhage</u> | ONSET BETWEEN ONSET AND DEATH <u>2 days</u> |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) <u>Hypertensive, arteriosclerotic cardiovascular disease</u> | <u>10 years</u> |
| (c) | | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|--|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT (Specify) SUICIDE HOMICIDE | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from Feb 8, 1956, to Feb 10, 1956, that I last saw the deceased alive on Feb 8, 1956, and that death occurred at 11:20 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

| | | | | |
|--|---|--|--|---------|
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | DATE THEREOF <u>2/13/56</u> | NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u> | LOCATION (City, town, or county) <u>Balto. City</u> | (State) |
| DATE REC'D BY LOCAL REG. <u>2-13-56</u> | REGISTRAR'S SIGNATURE <u>[Signature]</u> | 24. FUNERAL DIRECTOR <u>WIEDFELD & SON</u> | ADDRESS <u>GREENMOUNT AVE & 22ND</u> | |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7



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INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN:** The bottom copy may be retained by the hospital or attending physician. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

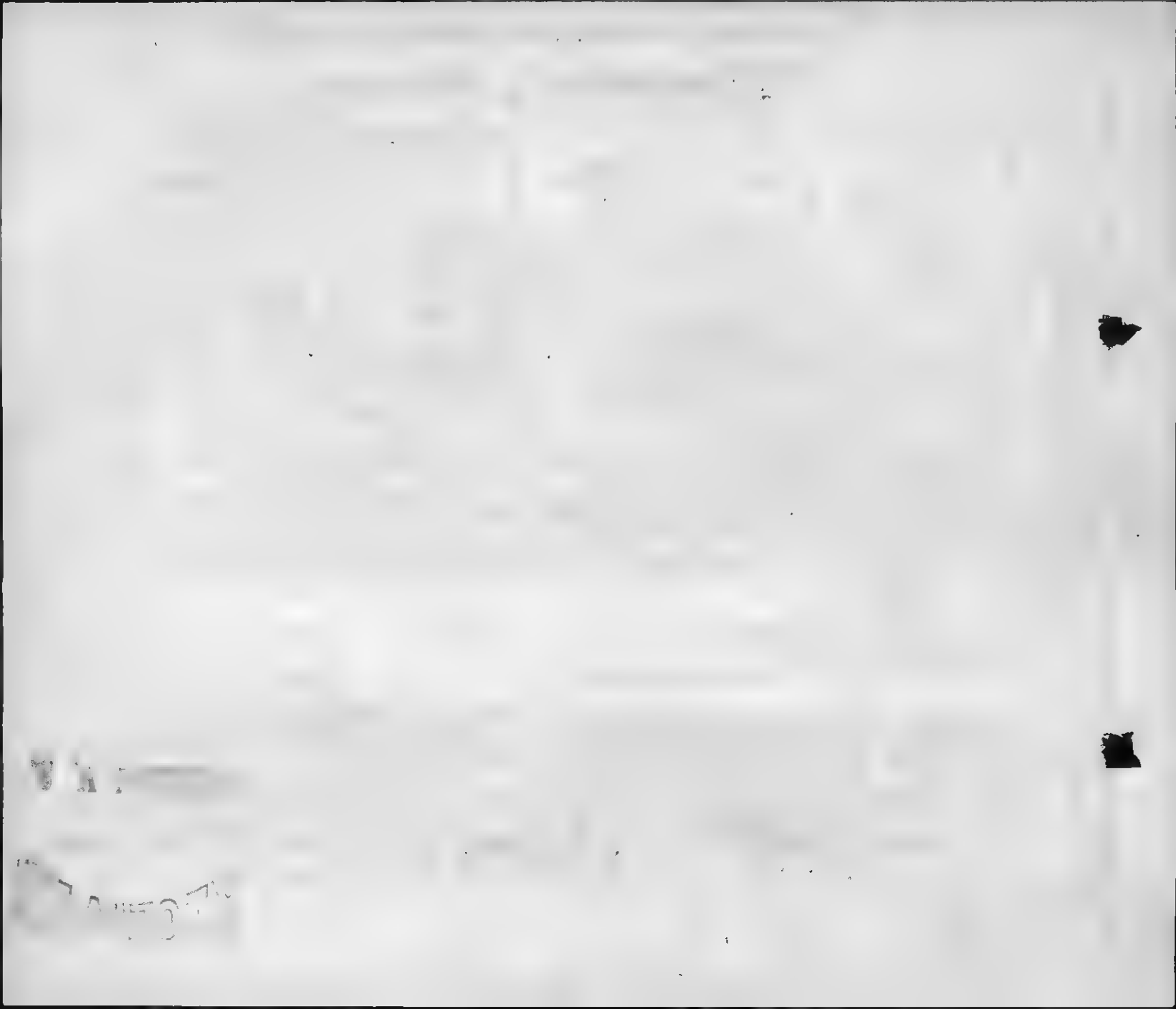
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1853 **CERTIFICATE OF DEATH**

01832

Reg. Dist. No. 181

| | | | | | | | |
|--|-------------------------|--|-------------------------|---|------------------------|---|-------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Harford</u> | | STATE <u>Tennessee</u> COUNTY | | CITY (If outside corporate limits, write RURAL and give nearest town) | | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| CITY OR TOWN <u>Penikese</u> | | LENGTH OF STAY (in this place) | | CITY OR TOWN <u>Athens</u> | | STREET ADDRESS (If rural give location) | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>US Army Hospital</u> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>JAMES</u> <u>RAY</u> <u>MURPHY</u> | | | | <u>February</u> <u>18</u> <u>1956</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS | |
| <u>Male</u> | <u>White</u> | <u>Single</u> | <u>23 Apr 23</u> | <u>32</u> yrs. | Months | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Soldier</u> | | <u>US Army</u> | | <u>Tennessee</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Deceased (Unknown)</u> | | | | <u>Deceased (Unknown)</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>Yes</u> <u>1974</u> | | <u>410-20-7653</u> | | <u>Official US Army</u> <u>Records, (phone) ACC, Md</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| <u>Subarachnoid hemorrhage, extensive</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| <u>Fracture 3-4-5-6 ribs and 2nd costal cartilage on right.</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| DUE TO (B) | | | | | | | |
| <u>Fracture, ribs, 1st, 2nd, 3rd</u> | | | | | | | |
| DUE TO (C) | | | | | | | |
| <u>Laceration, ventral line with hemorrhage</u> | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | | |
| <u>None (DOA)</u> | | | | <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| <input type="checkbox"/> | | <u>Route #40, between Aberdeen and Edgeood.</u> | | <u>Route #40, between Aberdeen and Edgeood.</u> | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| <u>12</u> <u>2000</u> <u>Feb</u> <u>18</u> <u>56</u> <u>M.</u> | | <u>While at work</u> | | <u>Vehicle accident</u> | | | |
| 22. I hereby certify that I attended the deceased from <u>DOA</u>, 19<u>56</u>, to <u>1956</u>, that I last saw the deceased alive on <u>1956</u>, and that death occurred at <u>M.</u> from the causes and on the date stated above. | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | | | 24. REC'D BY REGISTRAR | | | |
| <u>Removal</u> | | | | <u>Feb 20th 1956</u> | | | |
| 25. FUNERAL DIRECTOR'S SIGNATURE | | | | 26. REGISTRAR'S SIGNATURE | | | |
| <u>John G. Varring</u> | | | | <u>John G. Varring</u> | | | |
| 27. ADDRESS (Street, city, town, state) | | | | 28. ADDRESS | | | |
| <u>Athens Tennessee</u> | | | | <u>Athens Tennessee</u> | | | |



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01833

1854 CERTIFICATE OF DEATH

Reg. Dist. No. 182

| | | | | | | | |
|--|------------------|--|-----------------------------------|---|---|--|------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Harford</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR TOWN | |
| TOWN <u>Rural Bel Air</u> | | <u>3 years</u> | | TOWN <u>Rural Bel Air</u> | | <u>X</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| [First] <u>Martha</u> [Middle] <u>NELSON</u> [Last] | | | | [Month] <u>February</u> [Day] <u>10</u> [Year] <u>1956</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Female</u> | <u>Col.</u> | <u>Widow</u> | <u>2/11/1904</u> | <u>80</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| <u>Housewife</u> | | | | | <u>Harford Co., Maryland</u> | | <u>U.S.</u> |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>UNKNOWN</u> | | | | <u>Annie Gones</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| | | | | <u>Clarence Johnson</u> | | | |
| 18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 4. IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u> | | | | | | <u>Sudden</u> | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | <u>death</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO | | | | | | <u>?</u> | |
| (C) <u>Chr. cardio-vascular disease</u> | | | | | | | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>January 20 1956</u> , to <u>February 10 1956</u> , that I last saw the deceased alive on <u>Feb. 7</u> , 1956, and that death occurred at <u>6:45 a.m.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | DATE SIGNED | | | |
| <u>Missland P. Hudson M.D.</u> | | | | <u>Forest Hill, Md. February 10, 1956</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>BURIAL</u> | | <u>Feb/13/56</u> | | <u>Tubman</u> | | <u>Benson Harford Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>2-10-56</u> | | <u>Priscilla Foxwood</u> | | <u>Joseph J. Foster</u> | | <u>1401</u> | |

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN IN HOSPITAL: This form requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

THE UNIVERSITY OF CHICAGO

LIBRARY

1967

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

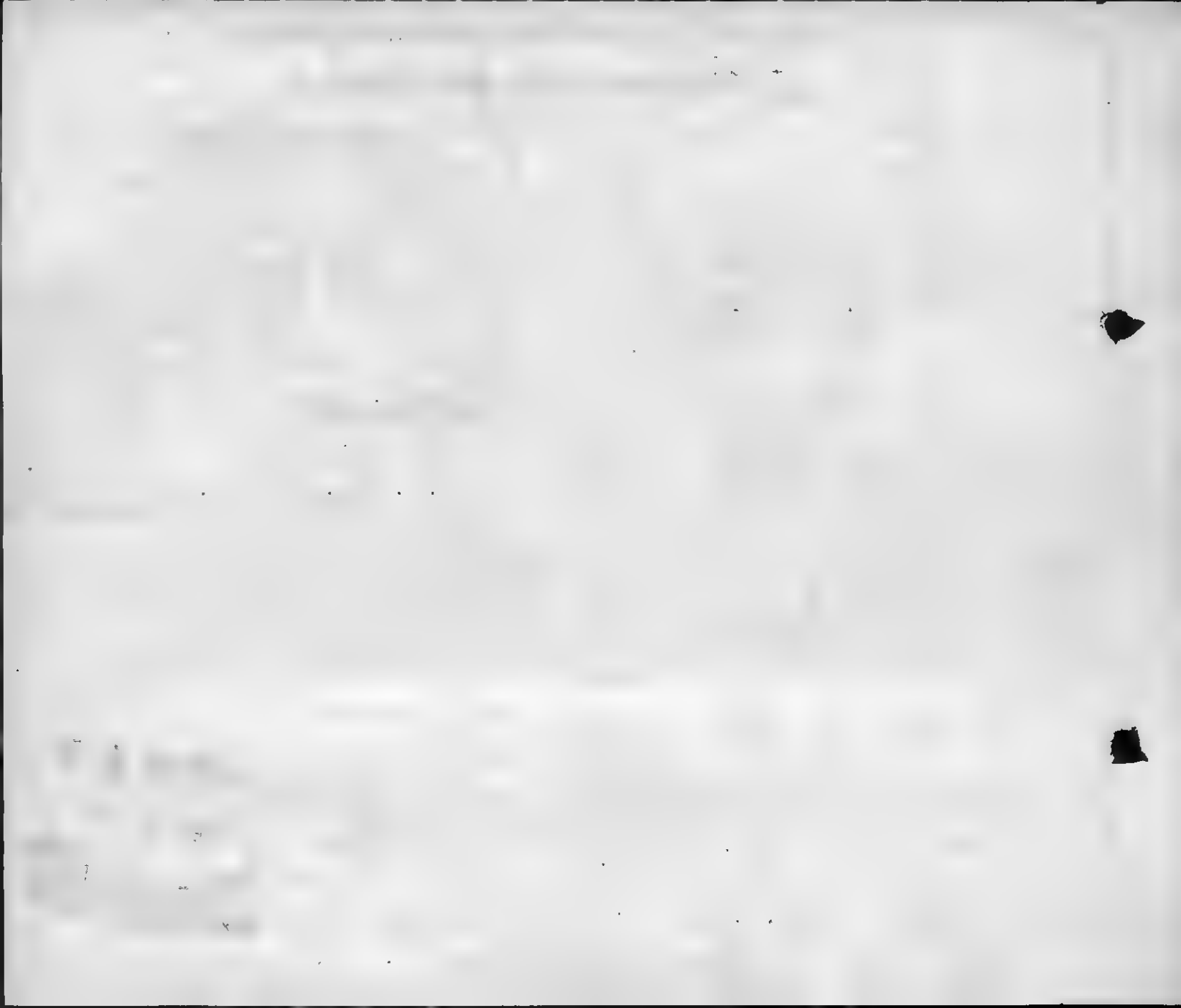
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01834

1833 **CERTIFICATE OF DEATH**

Reg. Dist. No. 187

| | | | | | | | |
|---|---|---|---|---|---|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Harford | | STATE Maryland | | COUNTY Harford | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) Bel Air | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) Bel Air | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Grafton Shop Road | | | | STREET ADDRESS (If rural give location) Grafton Shop Road | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) Mrs. Catherine Price | | | | 4. DATE OF DEATH (Month) (Day) (Year) February 2nd 1956 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed | 8. DATE OF BIRTH 20 Jan 1883 | | 9. AGE last birthday 73 yrs. | IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.) | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charles Dieter | | | | 14. MOTHER'S MAIDEN NAME Mary Smith | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS Mrs. M. Eliz. Treadwell, Box 266 Bel Air Md. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A) Cardio-respiratory failure | | | | | | INTERVAL BETWEEN ONSET AND DEATH 30 hours | |
| ANTECEDENT CAUSE(S) DUE TO (B) Cerebral embolus | | | | | | 55 hours | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Constrictive heart failure | | | | | | 1 year | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerotic cardiovascular Dis. | | | | | | 4 years | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from....., 19..49.., to....., 19..56.., that I last saw the deceased alive on..... 1..56.., and that death occurred at..... 1..15PM, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>M. D. 138 N. Main</i> | | | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF Feb. 6, 1956 | | NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | | LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <i>Priscilla Lowwood</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road #14 | | | |
| DATE Feb. 7, 1956 | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1834

CERTIFICATE OF DEATH

01835

Reg. Dist. No. 183-

| | | | | | | | |
|--|---------------------------|--|-------------------------------------|---|-----------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford & Grace</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conowingo, Md</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hosp.</u> | | | | d. STREET ADDRESS <u>Conowingo, Md</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Arthur</u> Last <u>Ragan</u> | | | | 4. DATE OF DEATH Month <u>February</u> Day <u>29</u> Year <u>1956</u> | | | |
| 5 SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb-12 1893</u> | 9. AGE (In years last birthday) <u>63</u> yrs | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanics</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u> | | 11. BIRTHPLACE (State or foreign country) <u>Conowingo, Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John W. Ragan</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Hannah Green</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-34-3331</u> | | 17. INFORMANT <u>Mrs John Ragan</u> | | Address <u>Conowingo, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis and hemorrhage</u> DUE TO (b) <u>Hypertensive and arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Cholera disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>not known</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic Congestion of lungs</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb. 11th, 1956</u> , to <u>Feb. 29th, 1956</u> , that I last saw the deceased alive on <u>Feb. 29th, 1956</u> , and that death occurred at <u>125 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>211 N. Union Ave., Harford, Md.</u> DATE SIGNED <u>Feb 29th 56</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Edward C. Lee, M.D.</u> | | | | PHYSICIAN'S NAME (Type) <u>Edward C. Lee, M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF <u>Mar 4, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u> | | 22d. LOCATION (City, town, or county) (State) <u>Peach Bottom Pa.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson, Rising Sun Md</u> | | | | ADDRESS <u>Rising Sun Md</u> | | 24a. REC'D BY REGISTRAR <u>G. L. Lewis M.D.</u> 24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u> | |

BERNARD V. S.

1835 CERTIFICATE OF DEATH

Reg. Dist. No. 185

| | | | | | | | |
|---|----------------------------------|--|---|---|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>HARFORD</u> | | MARYLAND | | STATE <u>MD</u> | | COUNTY <u>HARFORD</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAVRE DE GRACE</u> | | LENGTH OF STAY (In this place) <u>LIFE</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAVRE DE GRACE</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) <u>NORMAN WIDMER REYNOLDS</u> | | | | 4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>11</u> (Year) <u>1956</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u> | 8. DATE OF BIRTH <u>SEPT. 17, 1890</u> | 9. AGE last birthday <u>65</u> yrs. | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIREMAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>CANNING HOUSE</u> | | 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>THOMAS REYNOLDS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>CATHERINE SCHUTT</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u> | | 16. SOCIAL SECURITY NO. <u>215-12-156</u> | | 17. INFORMANT & ADDRESS <u>ST. W. REYNOLDS, PERRYVILLE MD.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 4. IMMEDIATE CAUSE (A) <u>Coronary occlusion</u> | | | | | | | |
| DUE TO ANTECEDENT CAUSE(S) (B) | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | | 21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from, 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at <u>4:45 P.M.</u> , from the causes and on the date stated above. SIGNATURE <u>Leviticus C Palmer</u> M.D. <u>Deputy Medical Examiner</u> ADDRESS (Street, city, town, state) <u>2112/56</u> DATE SIGNED <u>2/12/56</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | DATE THEREOF <u>2-14-1956</u> | | NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM</u> | | LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE, MD</u> | |
| 24. REC'D BY REGISTRAR DATE <u>Feb 14-1956</u> | | REGISTRAR'S SIGNATURE <u>C. T. Lewis M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Bill Madison & Mitchell</u> | | ADDRESS <u>HAVRE DE GRACE, MD</u> | |

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. Also this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. S.

FEB 15 1930

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01837

1836

CERTIFICATE OF DEATH

Reg. Dist. No. 182

| | | | | | | | |
|---|----------------------------------|--|---|---|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Harford</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bel Air</u> | | LENGTH OF STAY (in this place) <u>30 years</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bel Air</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Convalescent Home</u> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Lucy Alvirta Rhodes</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>February 27 1956</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Feb 18, 1877</u> | 9. AGE last birthday <u>78</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James H. Stewart</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>40-54-5271-5090</u> | | 17. INFORMANT & ADDRESS <u>For Butcher Shop</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 443X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Hypertensive Cardio-vascular Disease</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral Thrombosis (May, 1955 & Nov., 1955)</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Feb. 25</u> , 19 <u>56</u> , to <u>Feb. 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 25</u> , 19 <u>56</u> , and that death occurred at <u>7:20 a.m.</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Willard P. Hudson</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>March 1, 1956</u> | | NAME OF CEMETERY OR CREMATORY <u>Central Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Forest Hill, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>W. K. Bailey</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>W. K. Bailey</u> | | ADDRESS <u>1000 N. ...</u> | |
| DATE <u>March 1, 1956</u> | | | | | | | |

3 A 5

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1855 CERTIFICATE OF DEATH

01838

Reg. Dist. No. 182

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>HARTFORD</u> | | MARYLAND | | STATE <u>MD</u> | | COUNTY <u>HARTFORD</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BELAIR RD</u> | | LENGTH OF STAY (in this place) <u>32 years</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BELAIR RD</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Walters Nursing Home</u> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) <u>CORA E ROLOSON</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Feby 4 1956</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | | 8. DATE OF BIRTH <u>June 10 - 1871</u> | |
| 9. AGE last birthday <u>85</u> yrs | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House duties</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>House duties</u> | | 11. BIRTHPLACE (State or foreign country) <u>Catonsville Md</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | | | | | | | |
| 13. FATHER'S NAME <u>Richard Roloson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Frances Cash</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>✓</u> (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>✓</u> | | 17. INFORMANT & ADDRESS <u>Alger S Roloson</u> <u>BELAIR MD RD</u> | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u> | | | | | | <u>6 hours</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cardiovascular disease</u> | | | | | | <u>Probably 10 years</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | | 21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Nov. 16, 1955, to Feb. 4, 1956, that I last saw the deceased alive on Feb. 4, 1956, and that death occurred at 7:45 p.m. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Robert Barthol</u> MD | | | | ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u> | | DATE SIGNED <u>2-6-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | DATE THEREOF <u>Feb 7/56</u> | | NAME OF CEMETERY OR CREMATORY <u>Friends Burial Grounds</u> | | LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u> | |
| 24. REC'D BY REGISTRAR <u>2.6-56</u> | | REGISTRAR'S SIGNATURE <u>Priscilla Lowndes</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. [unclear]</u> ADDRESS <u>BELAIR MD</u> | | | |



CERTIFICATE OF DEATH

Reg. Dist. No. 1837

01839-

| | | | |
|--|------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUCE de GRACE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUCE de GRACE</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial Hosp.</u> | | d. STREET ADDRESS <u>617 JUNIATA ST</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Dolores</u> Middle <u>Scilli</u> Last <u>Scilli</u> | | 4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>1956</u> | |
| 5 SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/7/1897</u> |
| 9. AGE (In years last birthday) <u>59</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Italy</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Giovanna Di Amantis</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | |
| 17. INFORMANT <u>Mrs. Robert Whitney</u> | | Address <u>Ontario St., Harford County, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Arterio-Sclerosis Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic</u> (c) <u>Small Bladder Enlargement</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb. 27, 1956</u> , to <u>Feb. 28, 1956</u> , that I last saw the deceased alive on <u>Feb. 28, 1956</u> , and that death occurred at <u>7:45</u> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Charles J. Foley</u> M.D. | | DATE SIGNED <u>Mar 2/29/56</u> | |
| PHYSICIAN'S NAME (Type) <u>Charles J. Foley</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>3/2/56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Eun</u> | 22d. LOCATION (City, town, or county) (State) <u>Harford Co., Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Fox, Harford Co., Md.</u> | | 24a. REC'D BY REGISTRAR <u>Mar. 3-56</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis m.d.</u> | |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUENOS AIRES

MARYLAND STATE DEPARTMENT OF HEALTH

01840

1856 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 180

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH- COUNTY Harford CITY (If outside corporate limits, write RURAL and give nearest town) Abingdon TOWN Abingdon HOSPITAL OR INSTITUTION OR STREET ADDRESS | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Pennsylvania COUNTY Delaware CITY (If outside corporate limits, write RURAL and give nearest town) Lansdowne TOWN Lansdowne STREET ADDRESS (If rural, give location) 104 Mc Kinley Ave., | |
| 3. NAME OF DECEASED (Type or Print) E. Wood T. Sterling | | 4. DATE OF DEATH Feb 24 1956 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single | 8. DATE OF BIRTH Mar. 3, 1908 |
| 9. AGE last birthday 47 yrs. | | 10. AGE last birthday (If under 1 year) Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Bloomsburg, Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Jennie Sterling | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY No. 194-07-8982 | |
| 17. INFORMANT AND ADDRESS Jennie Sterling, Bloomsburg, Penna., | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 2. Immediate cause (a) Poisoning due to Carbon Monoxide | | | |
| Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> PLACE (Home, farm, factory, street, office bldg., etc.) Field (CITY OR TOWN) Abingdon (COUNTY) Harford (STATE) Md | | | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY 2/24/56 m. | | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? Fired auto exhaust into car | |
| 22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input checked="" type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> | | | |
| SIGNATURE Lerald C Palmer MD (Degree or title) | | DATE SIGNED 2/24/56 | |
| 23. BURIAL, CREMATION REMOVAL (Specify) Removal | | DATE THEREOF 2/25/1956 | |
| NAME OF CEMETERY OR CREMATOR Baker Funeral Home | | LOCATION (City, town, or county) (State) Bloomsburg, Columbia, Pa. | |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE Feb 28, 1956 Norma G. Moore | | 24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon Md. | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU A

1950



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 48 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

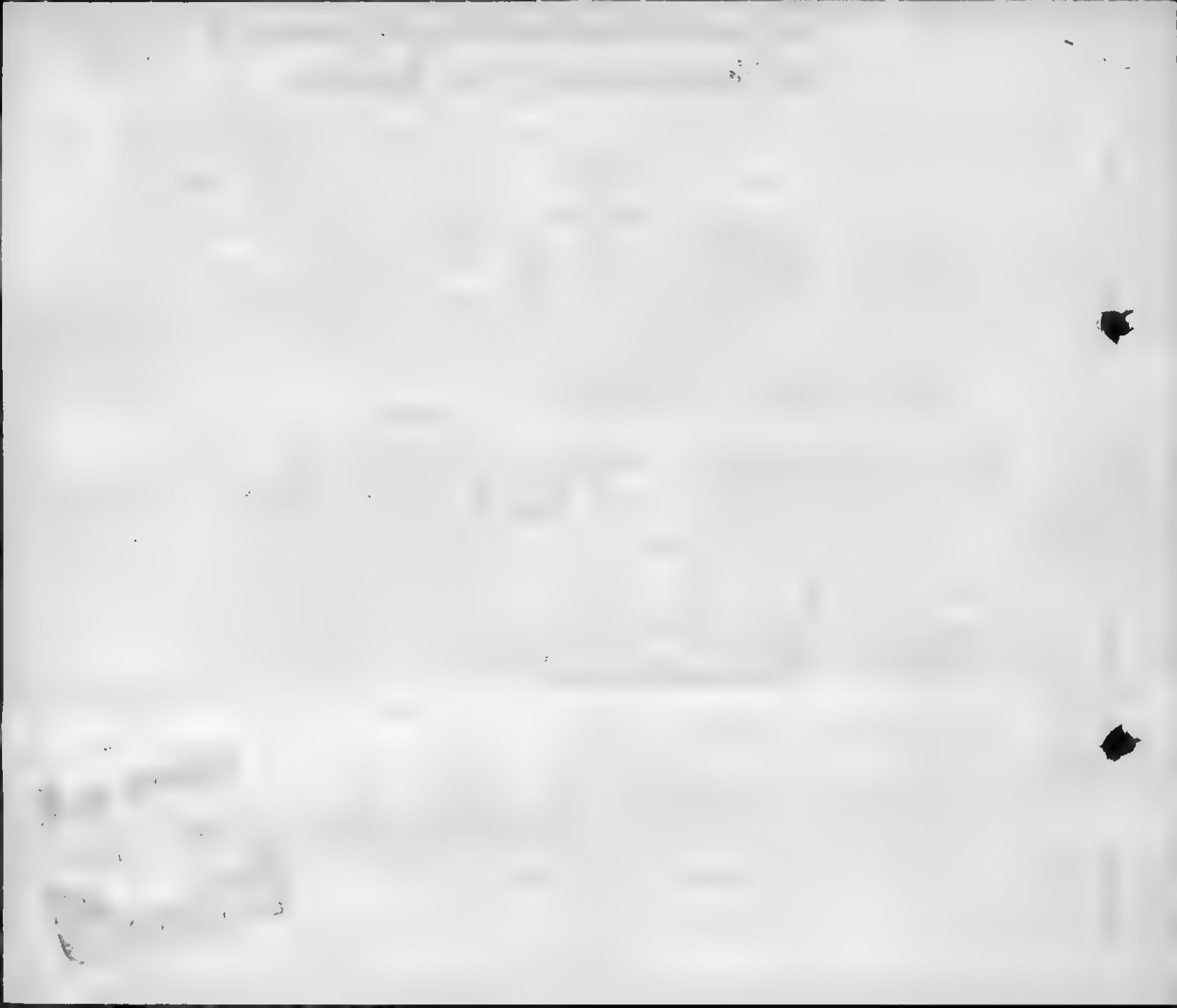
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01841

1838 CERTIFICATE OF DEATH

Reg. Dist. No. 180-

| | | | |
|--|---------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH COUNTY HARFORD STATE MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY HARFORD | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HAVRE DE GRACE | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN PERRYMAN | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS HARFORD MEMORIAL HOSPITAL | | STREET ADDRESS (If rural give location) | |
| 3. NAME OF DECEASED (Type or Print) MARY S. TAYLOR TANNER | | 4. DATE OF DEATH (Month) (Day) (Year) February 1 1956 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W | 8. DATE OF BIRTH 4-2-1878 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 9. AGE last birthday 77 yrs. |
| 11. BIRTHPLACE (State or foreign country) N. J. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOSEPH W. TAYLOR | | 14. MOTHER'S MAIDEN NAME ANNA E. STOCKHAM | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT & ADDRESS Dr. Lynn V. Finner, P. Aberdeen Md. | | | |
| 18. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 445X IMMEDIATE CAUSE (A) Vascular collapse (post-operative) | | | 42 hrs. |
| ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Hypertensive cardio vascular disease | | | |
| (C) Tumor of rectum | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION 1-30-56 | | 19b. MAJOR FINDINGS OF OPERATION Tumor of rectum | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. | | 21e. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 11-2 , 19 55 , to 2-1 , 19 56 , that I last saw the deceased alive on 2-1 , 19 56 , and that death occurred at 3:05 P.M. from the causes and on the date stated above. | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE SIGNED James W.C. Finner M.D. 330 S. Union Ave, Havre de Grace, Md. 2-1-56 | |
| DATE Feb 4-1956 | | 24. REC'D BY REGISTRAR John F. Garrison | |
| 25. FUNERAL DIRECTOR'S SIGNATURE John F. Garrison | | ADDRESS Aberdeen Md. | |



1839

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>HAVER DE GRACE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Aberdeen Md.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u> | | | | d. STREET ADDRESS <u>ABERDEEN Maryland</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>Virginia</u> Last <u>VERMILLION</u> | | | | 4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>26</u> Year <u>1956</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/25/1891</u> | 9. AGE (In years last birthday) <u>64</u> yrs. | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | 11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND BALTO, U. S. A.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | 13. FATHER'S NAME <u>J. Clinton COOKE</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Lucy DUNN</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> | | | |
| 16. SOCIAL SECURITY NO. <u> </u> | | | | 17. INFORMANT <u>Mr Francis E. Vermillion R.F.D. 1, Aberdeen Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pancreatitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | | | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>56</u> | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | | |
| 20f. (City or town) <u> </u> | | | | 20g. (County) <u> </u> | | | |
| 20h. (State) <u> </u> | | | | 21. I certify that I attended the deceased from <u>2-9</u> , 19 <u>56</u> , to <u>2-15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-15</u> , 19 <u>56</u> , and that death occurred at <u>3:15</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>James McC Finney</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>330 S. Union Ave, Haver de Grace Md</u> | | | |
| DATE SIGNED <u>2-21-56</u> | | | | PHYSICIAN'S NAME (Type) <u>JAMES MCC. FINNEY</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>2/29/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>New Balto National Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>5501 Frederick Ave</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u> | | | | ADDRESS <u>904 Hollins St.</u> | | | |
| 24a. REC'D BY REGISTRAR <u> </u> | | | | 24b. REGISTRAR'S SIGNATURE <u> </u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and is hereby certified to be true and correct. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILSON V. S.

FEB 20 1955



1857 CERTIFICATE OF DEATH

Reg. Dist. No. 182

| | | | | | | | |
|---|-------------------|--|----------------------|---|-----------------|---|------------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY HARFORD | | MARYLAND | | STATE MD. | | COUNTY HARFORD | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | | | |
| X TOWN CARDIFF | | 28 yrs. | | TOWN CARDIFF | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) OF DEATH: | | | |
| WILLIAM HENRY WELCH | | | | FEB. 15, 1956 | | | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| M | W | MARRIED | JUNE 10, 1887 | 68 yrs. | Months | Days | Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | | 12. CITIZEN OF WHAT COUNTRY? | |
| AMMUNITION LOADER | | U.S. G.O.U. | | DELTA, PA. | | U.S.A. | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| THOMAS WELCH | | | | REBECCA DICK | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS: | |
| No | | | | 215-03-0428 | | ELLEN G. WELCH, CARDIFF, MD. | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) Nephritis | | | | | | | |
| ANTECEDENT CAUSE (S) DUE TO Arteriosclerotic C-V Disease | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO Coronary Thrombosis | | | | | | | |
| STATING UNDERLYING CAUSE LAST, (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| M. | | | | | | | |
| 22. I hereby certify that I attended the deceased from 4/8/55 , to Feb 15, 1956 , that I last saw the deceased alive on Feb 15, 1956 , and that death occurred at 5:30 P M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE Jonah A. Hunt, M.D. | | ADDRESS Delta, Pa. | | DATE SIGNED 2/17/56 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| BURIAL | | 2-18-56 | | ST. MARYS | | PYLESVILLE, MD. | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | | |
| 2-18-56 | | Prueella Lowwood | | JOHN H. HARKINS, DELTA, PA. | | | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE A. J. JONES

90 1

1971

1840

CERTIFICATE OF DEATH

Reg. Dist. No. 185

| | | | | | | | |
|--|-------------------------------|--|---------------------------------------|--|-----------------|--|-----------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>HARFORD</u> | | STATE <u>MD</u> COUNTY <u>HARFORD</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD</u> | | TOWN <u>HARFORD</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD</u> | | LENGTH OF STAY (In this place) <u>50 YRS</u> | | STREET ADDRESS (If rural give location) <u>515 FOUNTAIN ST.</u> | | TOWN <u>HARFORD</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>515 FOUNTAIN ST.</u> | | | | STREET ADDRESS <u>515 FOUNTAIN ST.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>MABEL SYDONIA WHITEHEAD</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 7 1956</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>JAN. 16, 1879</u> | 9. AGE last birthday <u>77</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>MD</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>GEORGE F. LYDAIRD</u> | | | | 14. MOTHER'S MAIDEN NAME <u>SUSANNA M. WATKINS</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u> (If Yes, give war or dates of service) <u>—</u> | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | | |
| 17. INFORMANT & ADDRESS <u>MR. GUSTAVUS WHITEHEAD</u> | | | | | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION <u>HARFORD DE GRACE MD.</u> INTERVAL BETWEEN ONSET AND DEATH | | | |
| X IMMEDIATE CAUSE (A) <u>Heart attack - Coronary Heart Disease</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Hypertension</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>—</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>M</u> | | 21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan 3</u> , 19 <u>48</u> , to <u>Feb 7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 7</u> , 19 <u>56</u> , and that death occurred at <u>7 P.</u> M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>[Signature]</u> | | M.D. <u>[Signature]</u> | | ADDRESS (Street, city, town, state) <u>Harford, Md.</u> | | DATE SIGNED <u>2/9/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | DATE THEREOF <u>FEB. 10, 1956</u> | | NAME OF CEMETERY OR CREMATORY <u>IVY HILL CEM.</u> | | LOCATION (City, town, or county) (State) <u>PRINCE GEORGE CO., MD.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>[Signature]</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> | | ADDRESS <u>HARFORD DE GRACE MD.</u> | |
| DATE <u>Feb - 9 - 1956</u> | | | | | | | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



1858

CERTIFICATE OF DEATH

01845
180

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Harford MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa | | | | c. LENGTH OF STAY IN 1b 36 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS Joppa | | | |
| 3. NAME OF DECEASED (Type or print) First Amelia Middle Willick Last Willick | | | | 4. DATE OF DEATH Month Feb. Day 18 Year 19 56 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 15, 1882 | | 9. AGE (In years last birthday) 73 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Strums Schaefer | | | | 14. MOTHER'S MAIDEN NAME Cathie Fink | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT William H. Willick | | Address Joppa, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute pulmonary edema DUE TO arteriosclerosis of the heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 yrs DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Weakness Melancholy | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from June 1956 , to Feb 1956 , that I last saw the deceased alive on Feb 18 1956 , and that death occurred at M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE J. Ralph Horky M.D. | | | | ADDRESS (Street, city or town, state) Churchville Maryland. | | DATE SIGNED Feb 22 1956 | |
| PHYSICIAN'S NAME (Type) J. Ralph Horky | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Feb. 21, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY St. Stephens | | 22d. LOCATION (City, town, or county) (State) Bradshaw, Balto., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son | | | | ADDRESS Abingdon Md. | | 24a. REC'D BY REGISTRAR DATE Feb 22, 1956 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Norma Moore | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. It may be retained by the hospital or attending physician. A certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THOMAS A.

1905

EB

1000

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01846

CERTIFICATE OF DEATH

1841

Reg. Dist. No. 185

| | | | | | | | |
|--|--------------------------------------|---|---|---|------------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>HARFORD</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>HARFORD</u> | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>HAURE DE GRACE</u> | | LENGTH OF STAY (In this place) <u>6 HRS.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>ABERDEEN</u> | | <u>31</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL Hosp</u> | | | | STREET ADDRESS (If rural give location) <u>203 S. ROGERS</u> | | <u>1</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>CHARLES OSCAR WOLTERSBERGER</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>FEBRUARY 1 19 56</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>June 22-1894</u> | 9. AGE last birthday <u>61</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BIO RAILROAD Traction Supt.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>CHARLES WOLTERSBERGER</u> | | | | 14. MOTHER'S MAREN NAME <u>GERTRUDE PARKS</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk.</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS <u>Ethel J. Woltersberger Aberdeen Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 331X IMMEDIATE CAUSE (A) <u>Cerebro-Vascular Accident</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute Hypertensive Crisis</u> | | | | <u>12 hours</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Gen. Arteriosclerosis with BP 260/160</u> | | | | <u>5 years</u> | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>01 52 Jan 31 56</u> | | 21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan 31 19 56</u> , to <u>Jan 31 19 56</u> , that I last saw the deceased <u>alive on Jan 31 19 56</u> , and that death occurred at <u>12 40</u> M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>A. Sandeechi M.D.</u> | | M.D. <u>Bel Air, Md.</u> | | ADDRESS (Street, city, town, state) <u>Feb 1st 1956</u> | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial Removal</u> | | DATE THEREOF <u>2/2/56</u> | | NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Northwood Peruna</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Tarring Aberdeen Md.</u> | | ADDRESS | |
| DATE <u>Feb 4 1956</u> | | | | | | | |

CERTIFICATE OF DEATH

1881

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

DEATH

INTERVIEW

TESTIMONY

VERIFICATION

SIGNATURE

DATE

PLACE

REMARKS

TESTIMONY

VERIFICATION

SIGNATURE

DATE

PLACE

REMARKS

TESTIMONY

VERIFICATION

SIGNATURE

DATE

PLACE

REMARKS

TESTIMONY

VERIFICATION

SIGNATURE

DATE

PLACE

REMARKS

INSTRUCTIONS

BUREAU A. B.

FEB 7 1986

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-35 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1842 CERTIFICATE OF DEATH

01847

Reg. Dist. No. 183-

| | | | | | | | |
|---|---------------------------|--|-----------------------------------|--|-----------------|--|----------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>HARFORD</u> | | MARYLAND | | STATE <u>Md</u> | | COUNTY <u>Cecil</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Harre de Grace</u> | | | | TOWN <u>Port DePOSIT</u> | | 97X-2 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hosp</u> | | | | STREET ADDRESS (If rural give location) <u>Md.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Arrie Mathena</u> (Middle) <u>Wolford</u> (Last) | | | | (Month) <u>Feb.</u> (Day) <u>4</u> (Year) <u>19 56</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u> | 8. DATE OF BIRTH <u>3-20-1877</u> | 9. AGE last birthday <u>78</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| | | | | Months | | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Daniel Umbarger</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Fannie F. King</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) | | 17. INFORMANT & ADDRESS <u>Lt. Wolford, Port Deposit, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 422.1 IMMEDIATE CAUSE (A) <u>Beckham's accident</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular disease</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Tumor of adrenal (pheochromocytoma)</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION <u>2</u> | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from to that I last saw the deceased alive on <u>Feb. 4</u> , 19 <u>56</u> , and that death occurred at <u>12:00</u> P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Wm. K. Brenden</u> | | | | M.D. <u>Harre de Grace</u> | | DATE SIGNED <u>2-4-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>2-7-1956</u> | | NAME OF CEMETERY OR CREMATORY <u>Round Hill</u> | | LOCATION (City, town, or county) <u>Marion, Va</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>G. L. Lewis</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Peterson</u> | | ADDRESS <u>Port Deposit, Md.</u> | |
| DATE <u>Feb. 6 - 1956</u> | | | | | | | |

1955 CERTIFICATE OF DEATH

Form 100-101-1

1. Name of deceased: _____

2. Sex: _____

3. Date of birth: _____

4. Place of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Manner of death: _____

9. Signature of physician: _____

10. Signature of registrar: _____

11. Signature of informant: _____

12. Signature of funeral director: _____

13. Signature of coroner: _____

14. Signature of health officer: _____

15. Signature of registrar: _____

16. Signature of informant: _____

17. Signature of funeral director: _____

18. Signature of coroner: _____

19. Signature of health officer: _____

20. Signature of registrar: _____

21. Signature of informant: _____

22. Signature of funeral director: _____

23. Signature of coroner: _____

24. Signature of health officer: _____

25. Signature of registrar: _____

26. Signature of informant: _____

27. Signature of funeral director: _____

28. Signature of coroner: _____

29. Signature of health officer: _____

30. Signature of registrar: _____

BUREAU V. S.

FEB 7 1956

RECEIVED